Government Employees Health Association
Review of Options for 1984-1985

Introduction

Like its counterparts in the Federal Employees Health Benefits Program (FEHBP), the Association Benefit Plan has endured an unsettling two and one-half years. Economic pressures along with mandates from the Office of Personnel Management (OPM) have produced reductions in the benefit package and membership dissatisfaction without observable relief in premium levels.

Not surprisingly in light of the continuing inflation in health care, we see the same scenario troubling private sector employers as well. Clients contributing to the 1983 Hay/Huggins Noncash Compensation Comparison reported that in more than two-thirds of the cases premiums rose by more than 15 percent over the previous year. One-third of the participants made some sort of cutback in plan design in the past two years ranging from increased deductible and coinsurance amounts to reduction in first dollar coverage and increased employee contributions to premiums. The majority of employers reported proactive efforts geared to control of spiralling medical costs such as health promotion, employee communication programs, claims analysis, and membership in employer coalitions designed to effect health care costs.

Although the generic problem assuredly is not limited to the Association Benefit Plan, the Board is now faced with the decision of what measures it will authorize for 1985 against the backdrop of the distinctive circumstances surrounding the agency plan. These distinctive circumstances include:

- Limited prospective population - Membership is limited to agency personnel, therefore, the population base does not give as much manueverability to the Association as either the government-wide or unrestricted employee organizations plans enjoy.

- Restricted population segment - A portion of agency personnel have no choice of health plan, therefore, the responsibility of the Board to assure sufficient levels of coverage is intensified.

- A decline in membership - For the first time in its history, the plan suffered a net loss in its membership level. A principal reason for this was the reduction in the Association's benefits coupled with the availability of attractive FEHBP coverage at several hundred dollars annual savings to enrollees. A large portion of those members who did not anticipate a need for either the plan's comprehensive mental health coverage or generous catastrophic protection changed to another plan. An analysis done by the Insurance staff showed that 41% of those that left had not used the plan in the past year and that the balance were relatively light utilizers. Only four percent of those who changed plans had used the mental health benefits. Loss of the better risks could lead to higher premium costs, and further losses, in the future.

- Credibility with the membership - The negative reaction of members to the 1984 reductions and the Open Season loss suggests that benefit redesign should try to avoid further cuts so as to forestall wariness on the part of the membership.

- o Favorable Experience - The losses expected by Mutual of Omaha did not materialize. In fact, analysis of the paid claims through the end of 1983 leads us, and the Insurance staff, to believe that little or no premium increases will be needed for 1985. This should leave room for benefit enhancements without any significant rate increase -- the reverse of the 1984 redesign.

- o External elements - The options available to the Board are governed in part by what OPM policy will allow and by what the underwriter will be willing to do.

With the above considerations in mind, this paper outlines the alternatives available to the Board and discusses the positive and negative aspects of those alternatives. Specifically, it examines:

I. Plan Design

A. addition of a low option

B. general plan restructure

C. plan redesign to attract new members and/or control costs

II. Plan Administration

A. minimum premium arrangement

B. review of the underwriter's role

- stop loss arrangement with Mutual of Omaha

- alternative underwriters

III. Agency Initiatives

A. special subsidies

B. an employee assistance program

C. an employee communication program

IV. Employer Responses to Health Care Increases

A. Employer Actions

B. Flexible Spending Accounts

I. Plan Design

A. Addition of a Low Option

One alternative for the Board to consider is development of a low option for the plan as an alternative to the current plan's coverage and premium level. To be attractive and to protect enrollees against undue medical expense risk, a low option structured like those of the government-wide plans, yet sufficiently distinct from the plan's current option, would be advisable. Such an option is shown in Table 1.

The introduction of a low option would offer a choice in health care coverage to those employees and retirees who are now restricted from other FEHBP plans by virtue of their undercover status. It also would produce a more attractively priced alternative for those unrestricted agency personnel who value the in-house claims handling and service given by the Insurance staff, but who may not have need for the full comprehensive benefits offered by the current plan.

Medicare recipients and others covered by a spouse's group plan who need the current plan only as a supplement would probably find the low option equally appealing as conceivably would those eligible for the overseas medical program. Finally, low utilizers who left the plan this past Open Season for lower priced alternatives like the Blue Cross/Blue Shield Standard Option and the Kansas City based GEHA might be enticed to return.

However, the attraction that a low option would provide is a dual edged sword and has to be weighted against the effect it would have on the current plan. Given the limited population base of the plan, a low option could be the foremost disabling factor affecting the high option. This is because the net cost of paying claims for all members plus the administrative expenses incurred are shared equally by all enrollees.

TABLE 1

Possible Low Option Configuration

Coverage Area	Current Plan	Possible Low Option
Inpatient	$200 per admission, 100% thereafter	$400 per admission, 90% thereafter
Surgery	100% of R&C outpatient 80% of R&C inpatient	Scheduled amount producing about 75% of R&C
Major Medical	$200 per calendar year, maximum of two, 80% thereafter	$250 per calendar year maximum of three, 75% thereafter
Catastrophic	$1,000, including mental health	$2,500, excluding mental health
Mental and Nervous		
Inpatient	100% for 60 days above $200, thereafter 80% to catastrophic limit	30 days at 90% above $400, 75% of next $20,000, then 100% up to $50,000 lifetime maximum
Outpatient	50% of charges for 50 visits, after $200 major medical deductible	$30 per visit with 50 visit limit
Biweekly Cost: Self	$ 44	$26
Family	$110	$68

NOTE: The cost of the high option would increase from the current level of $40 Self and $100 family because of anti-selection.

The loss to the high option of Medicare recipients, those with other group protection, and those eligible for the overseas medical program would each exert an upward pressure on the high option premium. Further, the migration of low utilizers from the high option would exacerate the situation. The experience-rated cost of providing high option benefits for a reduced group populated heavily by high utilizers could become prohibitively expensive.

A plan with a large population base, like the Service Benefit plan, can afford to take a calculated risk and actively compete with its own high option by offering a generous low option. A plan with a finite population such as your own does not have that latitude. The population remaining in the high option would be required to shoulder an increasingly prohibitive premium amount that eventually would preclude its continuation.

Additionally, a low option would increase the administrative effort. Claims examiners would need to be trained in the new coverage levels and a dual claims processing operation, one for each option, would need to be maintained. Also, OPM demands that individual options stand on their own merits and requires separate accounting and record keeping.

Hay recommends the Board not institute a low option. If the Board were to continue one level of coverage, we believe items outlined below in I. C. be considered for adoption. If the Board were to adopt a low option, we recommend the high option not be changed for 1985. A decision on a low option should be made no later that the end of March, 1984 to give the underwriter and OPM as much notice as possible to evaluate the proposal.

I. B. General Plan Restructure

In the face of a large premium increase for 1984, the Board appropriately studied and implemented a number of benefit reductions. When Hay began this study, there was concern that

further cutbacks might be needed to re-establish a competitive rate. However, with the favorable reserve situation that has developed there will probably be no need for benefit cutbacks in 1985. Accordingly, the restructure ideas discussed in this section are not immediately relevant but may be needed in the future.

One method plan sponsors have used to generate premium economies and yet maintain comprehensive coverage is to move from a basic/major medical benefit design to a "comprehensive" medical plan. The former, typified by the Association plan prior to 1984, provides payment in full for basic hospital and surgical expenses, then introduces a corridor deductible before partial reimbursement of outpatient expenses. The latter plan design assesses a deductible before any expenses are covered in a calendar year, and, after satisfaction of the deductible, may reimburse different categories of charges at varying coinsurance levels. Both types may provide catastrophic stop loss provisions.

The front-end deductible feature imposes some degree of cost sharing on any plan user and may encourage a degree of caution in the discretionary use of health care. Elimination of the basic first-dollar coverage feature also can produce savings for the plan sponsor who shifts from the former to the latter plan configuration.

A redesign of the Association plan as a comprehensive offering would produce little, if any, economy over the present benefit program. The cost sharing the present benefit arrangement imposes on hospital and surgical expenses would substantially counter any savings a front-end deductible might encourage. Thus, a major plan redesign at this point would not produce a substantively lower premium and might weaken the credibility of the membership which has only recently accomodated itself to the 1984 changes.

Mental and nervous benefits - Hay recognizes the Board has attempted to maintain comprehensive care for mental health treatment for the benefit of both its covert and noncovert enrollees. The use of mental health care provisions accounted for 14% to 15% of the plan's costs last year. A typical FEHBP plan's mental health cost, even for a full benefit, is no more than 7% of premium.

The Board may want to consider trimming back its mental health provisions. This would run counter to its established position, but would save the plan premium dollars and bring it into line with the reduced mental health care options now available under the Federal Program.

As another alternative, the Board may choose to leave the mental care provisions intact, but reduce the utilization by introduction of an expanded agency employee assistance program (see III. B. below).

I. C. Plan Redesign to Attract New Members and/or Control Costs

The degree of latitude that the Board will have in making any plan changes will be governed in part by OPM policy decisions on the degree of benefit changes that will be accepted for 1985. Over the last three years OPM policy has allowed no plan increments without offsetting reductions. However, historically OPM has deviatated somewhat from public policy to accomodate the Association and may do so this year as well.

The plan's 1983 experience has produced favorable results; 1984 premiums can be expected to generate more of a savings. A part of the positive reserves could be used to purchase benefit increments if OPM were to approve such action. In the event the Board decides to retain one option, we suggest the following coverage provisions be examined.

(1) Dental coverage - Dental care provisions typically provide no more than $200 to $300 worth of routine protection annually in a given family setting. This level of reimbursement runs counter to the fundamental purpose of health care benefits which is to provide financial protection for unforeseen medical expenses. However, in general employees perceive dental benefits to be a valued item. Specifically, Association enrollees have asked for dental protection and some have elected other options to be able to have it. The addition of a modest dental plan would increase TOTAL premiums by 5%.

(2) Routine physicals - Members have told the Insurance staff they believe the plan is deficient in not offering coverage for routine physicals. Typically, indemnity plans only provide benefits for expenses that are medically necessary, precluding routine care such as physicals or immunizations. Some health care proponents believe routine check-ups through early disclosure of chronic conditions serve to reduce overall medical costs.

Federal employees who value routine care can elect a health maintenance organization alternative or GEHA-Kansas City. Obviously, these are not options for your covert population. If the Board chose to make this benefit available, it could do so for approximately a 2% increase in premium.

Adoption of either (1) or (2) would add cost to the premium dollar without substantively improving plan coverage. On the one hand, the money invested in the benefits could improve enrollee morale since the changes would address perceived deficiencies; on the other hand, adding benefits when premiums are already high could invite criticism.

(3) Some changes could be made at little or no cost; such as:

(a) assessing the $200 hospital deductible on a per calendar year basis rather than on a per admission basis which would cost 0.3% of total premium;

(b) introduction of a cost-saving skilled nursing facility provision in lieu of continued hospitalization could possibly be done for no additional premium; and

(c) increase of the coinsurance rate across the board from 80% to 85% for inpatient surgery and introduction of a mandatory second surgical opinion program for certain non-emergency procedures. Here again, the savings could offset the added coinsurance cost.

The pricing anticipates coverage of the cost of the second opinion in full; reimbursement of 85% of reasonable and customary charges, if the second opinion confirms the advisability of the surgery; and reimbursement of 80% of reasonable and customary charges if a second opinion were not obtained or if that opinion did not confirm the need for surgery. Typically a mandatory second opinion program covers designated non-emergency, common operations that are used for conditions amenable to non-surgical treatment modes.

None of the three enhancements involve significant cost; options (b) and (c) may produce some claims savings. Additionally, with incorporation of items (a) and (c), the membership would see a modest reinstatement of prior benefits.

II. Plan Administration

A. Minimum premium arrangement

Some of the FEHBP plans have found it advantageous to arrange the flow of subscription income under a minimum premium arrangement. Currently, Mutual of Omaha is paid 97.5% of the subscription income by OPM and pays claims with these dollars. Since Mutual of Omaha must pay a state premium tax the money paid in taxes is lost to the use of the plan.

A minimum premium arrangement redirects the flow of subscription income. The majority of the premium dollar is paid to an account-held by the carrier; checks for claims payment, whether processed by the carrier or the underwriter, are written against that account. Since the FEHBP carriers are not subject to state premium tax, the amount of the tax is saved. Typically a small portion of the premium dollar continues to be funnelled to the underwriter who, under any circumstances, retains the same risk obligation, namely to provide assets to cover claims costs if the carrier-held account is not adequate to do so.

In deciding whether or not to pursue a minimum premium arrangement, the Board should weigh three major considerations: the potential savings are small, approximately 1.8% of premium; the arrangement could place additional administrative burden in the areas of investment and accounting on the Insurance staff; and, historically, Mutual of Omaha has not been a proponent of minimum premium arrangements.

II. B. Review of the underwriter's role

It is reasonable for an employer to periodically ask for competitive bids to make sure that the employer is receiving the best service. With a fully experience-rated plan, such as the Associaton Plan, the level of premium is not the main concern

because the plan will pay about the same total cost to any underwriter over the long run. Through discussion with the Insurance staff, it is also our opinion that there are no problems with the service provided by Mutual. Therefore, the only reason for looking at other underwriters would be if Mutual is not willing to go along with some of the initiations that the Board may want to take.

Currently the plan is fully underwritten by Mutual of Omaha. OPM oversight of the contract assures that Program dollars serve only for Program ends, and, that service charge amounts paid to the underwriter are not excessive. By virtue of the plan's experience-rating, i.e., gains and losses from prior years are reflected implicitly in current premium amounts, the only risk borne by Mutual of Omaha is that the Association might choose to cancel the contract at a time when the reserves were insufficient to cover outstanding claims.

The underwriter handles some claims administration and controls the flow and investment of premium dollars with the exception of the administrative expense allowance the Association receives directly. For more than thirty-five years Mutual of Omaha has been a willing partner in the discrete handling of certain enrollees claims.

The way that Mutual of Omaha constructs premiums is to predict each future year's claims as a percentage increase over the last year. The underwriter bases the projection on actual paid claims each month rather than on an incurred claims basis. The actual paid claims basis can produce a distorting effect and may have contributed to the overstatement of the claims projection for 1983. We believe the Association would enjoy more accurate rate projections, and less fluctation, if Mutual of Omaha agreed to calculate rates on an incurred basis.

The preliminary results of 1983 operations show the plan to have a positive ending special reserve of at least $3,000,000. 1984 projections suggest this year will also see a gain on operations. The estimated gain on operations can either be retained to bolster the reserves or be used to increase the benefits or reduce the premium.

The overall cost of the plan is not changed by the use of excess reserves. The cost remains a function of the utilization of plan benefits by members plus the cost of administration. However, the risk exposure the underwriter is willing to undertake is related directly to the reserve level. The higher the reserves, the lower the underwriter's risk; conversely, the lower the reserve level the higher the risk to the underwriter. Therefore, the level of risk Mutual of Omaha is ready to entertain for 1985 is a point of consideration.

The consideration of use of paid claims as the projection method and general conservatism on rate matters has led Mutual in part to insist on rates that were too high for a particular plan year. Of course, any excess rates will eventually be used to hold down future rates so the money is not lost but the possibility of driving away members, as in the last open season, argues for the lowest rates possible each year.

We suggest that the Association review the 1984 rate setting situation and the payments for 1985 with Mutual as soon as possible. If a frank discussion indicates that they are not willing to be more flexible in the future then the Board may consider, for nothing more than a point of leverage, proposing to the underwriter that the Association self-insure and purchase only stop-loss, reinsurance protection from Mutual of Omaha. As a self-underwritten plan, the Association would be guaranteeing to enrolles that the premiums collected were sufficient to cover claims and administrative expenses. To protect against the eventuality claims costs would exceed premium income, the Association could purchase

re-insurance from an underwriter like Mutual of Omaha. A re-insurer guarantees payment of claim amounts that exceed either an individual or aggregate stop-loss point. By self-insuring the Association would be able to cut premiums as close to the bone as possible by virtue of removing the underwriter's risk exposure. Through purchase of stop-loss, reinsurance protection from Mutual of Omaha, the Association would be guaranteeing enrollees all legitimate claims would be honored. The cost for the reinsurance coverage would be built in as a stated portion of the plan premium.

Mutual of Omaha, faced with the prospect of reinsuring a self-underwritten program, would be justified in highlighting potential negative aspects of the arrangement: the plan would be assuming far greater responsibility for cash management, investment of funds, complete claims administration, accounting and reporting duties, and would be losing the value of Mutual of Omaha's experience in these areas.

On the one hand, the very real potential exists that Mutual of Omaha would not agree to such an arrangement and would end its relationship with GEHA. On the other hand, assuming that Mutual of Omaha would not move to terminate the policy, but rather would negotiate the level of risk it was prepared to undertake, the Association would have a position from which to bargain.

If Mutual of Omaha is not willing to cooperate in Board decisions, the Board may want to consider soliciting a new underwriter. Normal searches for underwriters involve three main phases: invitation of six or eight insurers to bid on a specified level of benefits for a specified population; review of the proposals and subsequent invitation extended to two or three who meet the organization's criteria for the purpose of clarifying proposals; and finally, the choice of the new underwriter. Ordinarily the process takes a minimum of three months or more. In the case of a FEHBP plan, additional time must also be allotted for OPM review.

The Association's search for a new underwriter will be complicated by the classified nature of much of the plan's documentation. The usual field of six to eight invitees with two or three key bidders would probably be reduced sharply. Indeed, it is questionable whether any underwriter would cooperate with the agency to the extent that Mutual of Omaha has. However, until the insurance industry is contacted, we can only speculate on the willingness of underwriters to bid on a proposal where specific group demographics and utilization statistics are not available. We believe most underwriters would dismiss the request for proposals as nothing more than being asked to buy the proverbial pig in the poke.

In summary, the Association should consider asking Mutual of Omaha 1) to shift to an incurred claims basis for its rate projections and 2) to use a portion of the excess reserves to reduce premiums or increase benefits. If Mutual of Omaha is not willing to pursue these alternatives, a bargaining position for the Association would be to suggest the organization would self-insure and purchase only reinsurance from Mutual of Omaha. As an alternative, the Board may want to consider a search for a new underwriter.

III. Agency Initiative

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II. B. Employee Assistance Program

The Board might want to consider the use of an agency sponsored assistance program independent of the health plan. One alternative that private sector employers are turning to nationwide is use of employee assistance programs (EAP).

EAPs are programs established in organizations that provide employees with help in resolving or solving any personal problem that may or may not affect their job performance. Employee problems may include family/marital problems, emotional problems and substance abuse. Depending on the design of the EAP, employees may self-refer or may be prompted to use the EAP on recommendation by a supervisor. An EAP generally is equipped to assess the needs of an employee, provide crisis-intervention and short term therapy (two or three sessions with a trained professional) for situations that will respond to immediate improvement, and, for long-term needs, provide referral to appropriate community based resource groups. A properly run EAP will follow-up on and coordinate employee care to assure that providers are not over-utilizing and will take proactive steps to encourage healthier life styles among the workforce. The EAP services can cover dependents as well as employees. We understand the agency now provides similar types of counselling services to its employees in-house. Contracting with an EAP would expand these services to dependent family members and provide an importnat third party outlet for those employees who are hesitant to use the in-house program.

In addition to EAPs, the Washington area employers are being offered a new alternative, a pre-paid mental health assistance plan. The plan will provide mental health care through a network of over 150 professionals under contract throughout the metropolitan area. Plan sponsors suggest through use of peer review and emphasis on care in the less costly outpatient environment, the plan can save Washington employers 20 to 25 percent of the cost of providing employees sound mental health care. We have been assisting this

plan, the Metropolitan Psychiatric Group, in design of rates and benefits and are impressed with their innovative approach to a very difficult area of health care design.

Either an EAP or the prepaid mental health plan could serve to subsidize the health benefits plan. Insofar as enrollees and dependents used either program to address emotional conditions, utilization of the mental and nervous provisions under the health benefits plan could be alleviated. By providing more generous reimbursement of professional expenses under an alternative program than under the health benefits plan, employees would be encouraged to use the optional offering. Theoretically the optional program's emphasis on patient case management and cost-effective provision of care would reduce the overall cost of mental health treatment.

The use of either optional plan has limitations. First, both approaches are community-based and would serve only employees in a given geographic area. Second, if employees chose to receive recommended long-term care by use of a privately selected physician, mental health utilization under the health plan could increase. Third, the offering of either program would cost the agency money that would not be offset by employee contributions. Fourth, the EAP would duplicate in-house programs now available to employees only.

III. C. Employee Communication Program

In order to increase employee awareness of cost-effective use of the plan, the Board might want to endorse an employee communication program. If by nothing more than the increase in premium levels, the agency workforce recognizes something needs to be done in the health care area. An employee communication program could be geared to tell the individual what he or she can do to improve the situation.

The Insurance staff has already taken an initial step in a communications campaign by use of informational fliers that accompany claims payments. The agency might want to consider commiting the time and money to build on this basis through a long-range program designed to change employee health care use patterns. Newsletters, employee letters, lunch-time programs, and/or bulletin board postings could build on a central theme of healthier individuals working together to build a "healthier" health benefits plan. A key factor that would bear repetition is that premium levels are driven by the dollar amount of claims presented for payout.

Publication and presentations could emphasize cost containment features of the plan like use of ambulatory surgi-centers, pre-admission testing performed on an outpatient basis, and use of the second surgical opinion provision. Additionally, the program could be dovetailed with the symposia and services the agency medical department now provides. If these efforts were built arond a central theme with a recognizable logo and were produced on a routine basis, they could produce beneficial long-range effects.

IV. Employer Responses to Health Care Increases

A. Employer Actions

Appendix A, drawn from the 1983 Hay survey of 854 employees nationwide, chronicles actions taken by private sector organizations to help control health care costs. Through a combination of the programs offered by the agency's medical department, the Board's plan design decisions and the Insurance staff's review of claims utilization, your organization is either pursuing the majority of these items, or, as appropriate, has them under active consideration.

The one avenue private sector employers have available to them, but that, thus far, has eluded FEHB plans, is the vehicle of an employer coalition for the purpose of medical care cost containment. If FEHB plans that agreed to work together could identify geographic areas where they represented a significant portion of the health care purchasing population, a coalition could attempt to exert some effect on providers of care in that area through joint negotiations with those providers, sponsorship of a peer review group, and/or thorough claims analysis.

B. Flexible Spending Accounts

Some employers are helping employees shoulder a portion of increased out-of-pocket expenses for health care by offering employees a limited tax shelter in the form of a flexible spending account. A flexible spending account is a portion of salary an employer allows an employee to access on a pre-tax basis to meet certain expenses not covered by the employer's benefits program, e.g., the deductible and coinsruance amounts under the health care plan. Ordinarily, an employee pays deductibles and coinsurance amounts with after-tax take-home dollars. Under a flexible spending account, an employee can submit those uncovered items against the account and be reimbursed through that account in pre-tax dollars. The flexible spending account reduces the gross taxable salary amount to the employee and makes the health care cost sharing more pallatable by allowing it to be met with pre-tax dollars.

The tax advantages provide an incentive for employers to introduce a flexible spending account. However, if one of the goals of increasing health care cost sharing is to raise consumer consciousness, the tax advantages under a flexible spending account dilute that effect.

Although the legislative and regulatory framework for flexible spending accounts has not yet been formally addressed by the Congress or the Internal Revenue Service, many private sector

employers are setting them up. OPM's compensation policy office is skeptical over their legality in the Federal sector. We suggest if the Board is interested in investigating this alternative, the agency's Office of General Counsel evaluate its feasibility under Federal pay statutes.

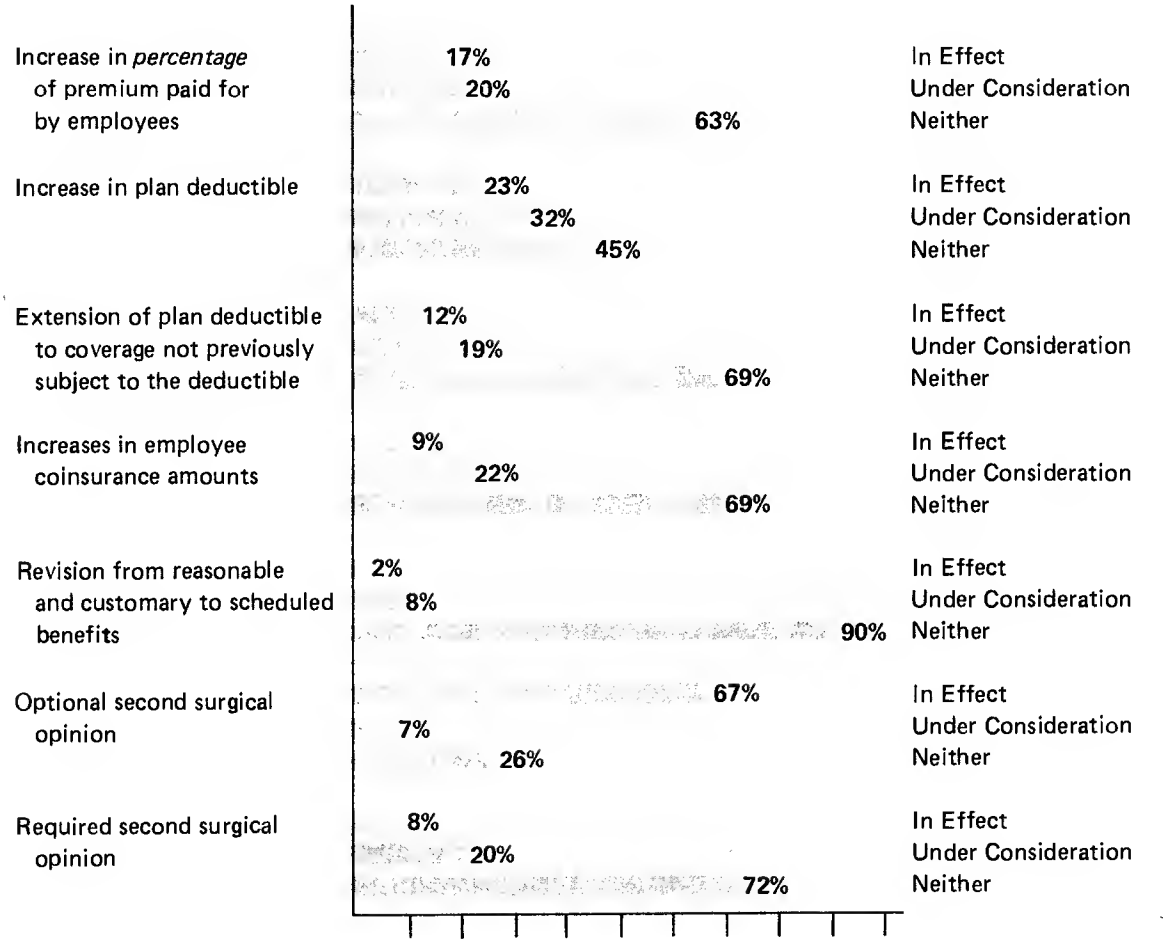
A

I. PLAN DESIGN

Forty-seven percent of health plan design changes shown below were made with some 'other' type of plan changes. Of these, 26% made medical plan improvements, 4% made other plan improvements, and 17% made both medical and other plan improvements. However, 53% of the reported changes were made without any benefits plan improvements.

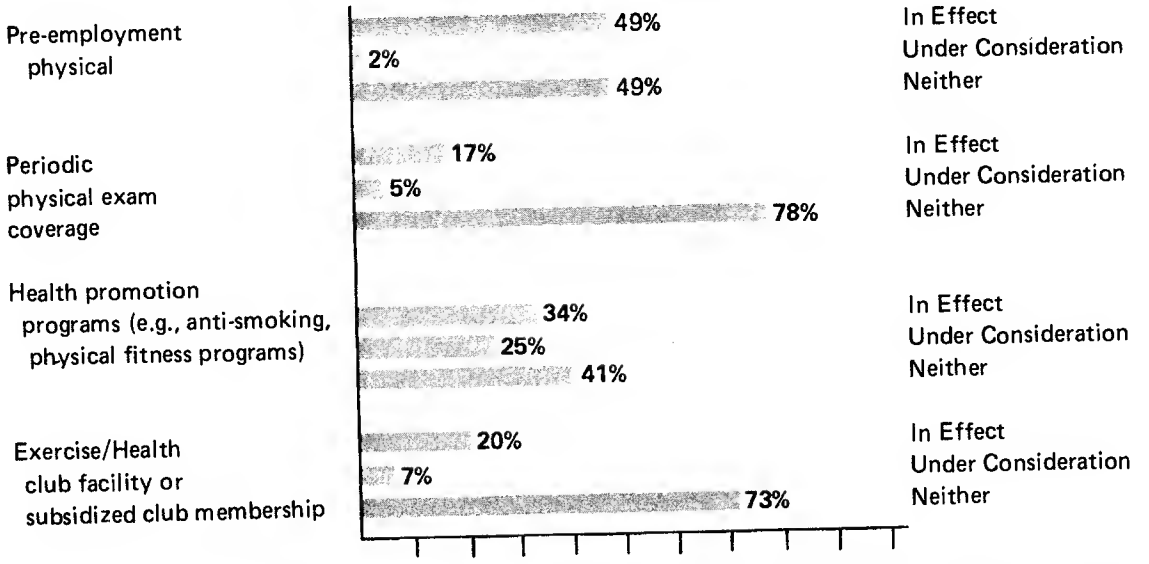
Twenty-seven percent of the participants increased their major medical deductible and/or extended this deductible to other coverage not previously subject to the plan deductible.

Table 4.12 Health Plan Changes to Help Control Medical Costs
Change Undertaken Within Last 2 Years



II. HEALTH PROMOTION

Table 4.13 Employer Health Promotion Programs Designed to Control Medical Costs



Twenty-two percent of those surveyed presently have a specifically stated employee communications program. Forty percent are currently considering this option.

Table 4.14 Employer Communication Programs Designed to Control Medical Costs

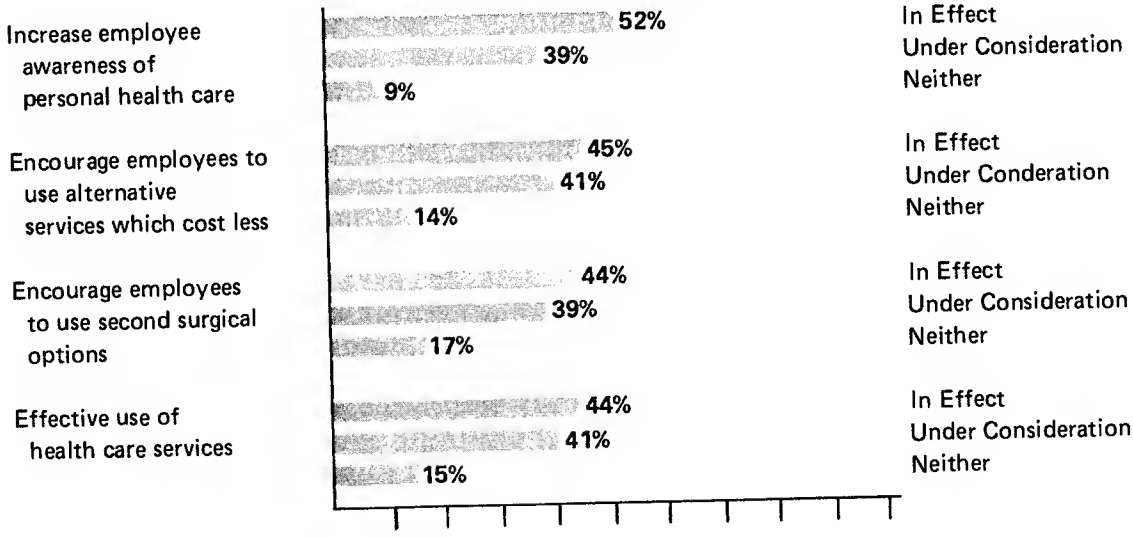
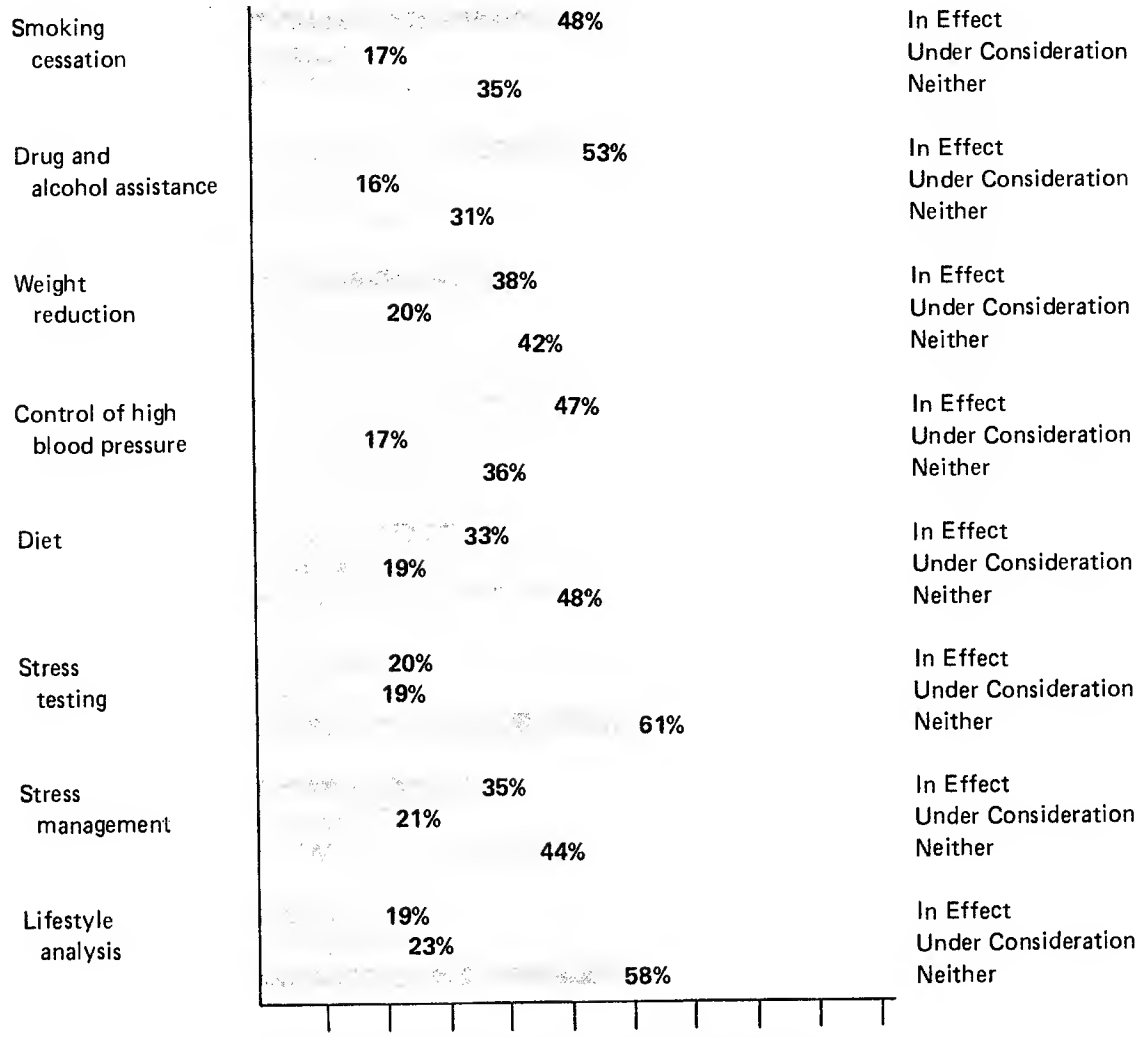


Table 4.15 Features of Employer Health Promotion Programs



Sixty-three percent of the surveyed health promotion programs are operated by company staff, ten percent use an outside agency while 27% use a combination of both.

Most (63%) exercise/health club programs provide facilities at the employers' location while 38% subsidize membership fees of outside facilities.

Table 4.16 Percentage of Employees Actively Participating in Health Promotion Program

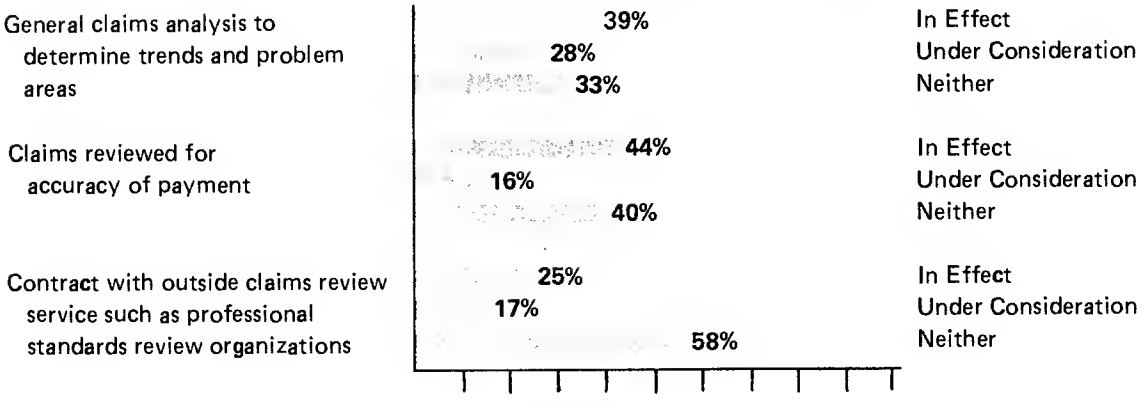
	Industrial		Fin./Svc.		Total	
	No.	%	No.	%	No.	%
⩽ 1-4.99	3	12	3	7	6	9
5-9.99	4	16	7	17	11	17
10-14.99	4	16	7	17	11	17
15-24.99	7	28	8	20	15	23
25-49.99	1	4	9	22	10	15
50-74.99	5	20	6	15	11	17
75-100	1	4	1	2	2	2
Total	25	100	41	100	66	100

Table 4.17 Percentage of Employees Actively Participating in Exercise/Health Club Programs

	Industrial		Fin./Svc.		Total	
	No.	%	No.	%	No.	%
⩽ 1-4.99	10	23	5	15	15	19
5-9.99	7	16	6	18	13	17
10-14.99	4	9	6	18	10	13
15-24.99	10	23	9	28	19	25
25-49.99	10	23	5	15	15	19
50-100	3	6	2	6	5	7
Total	44	100	33	100	77	100

III. CLAIMS ANALYSIS

Table 4.18 Employer Claims Analysis Programs

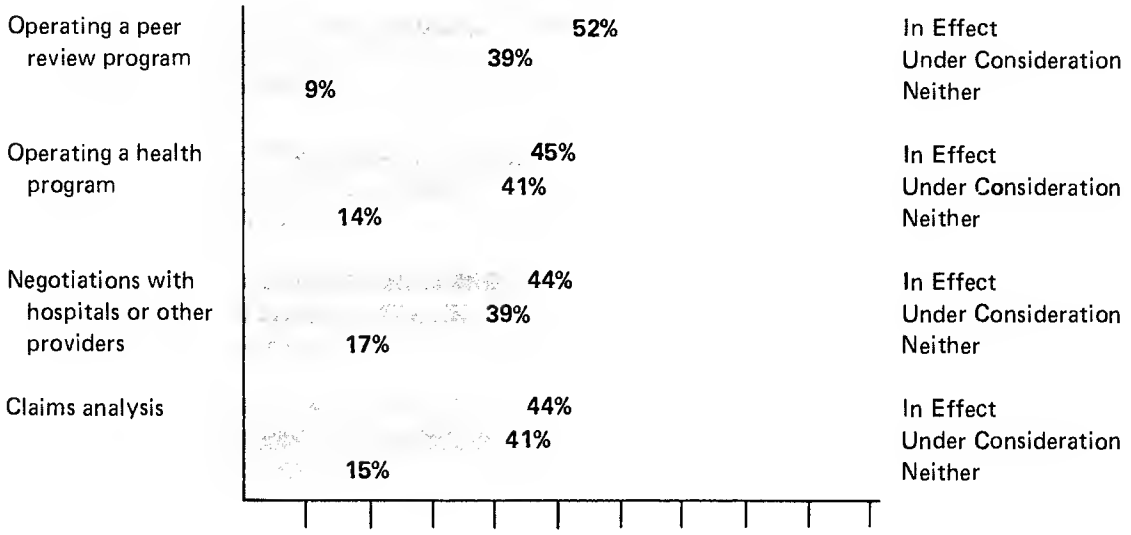


IV. COST CONTAINMENT COALITIONS

Thirty-one percent of those surveyed participate in a coalition of other organizations for the purpose of medical care cost containment. Thirteen percent are considering such a strategy.

Table 4.19 Employer Coalitions to Help Control Medical Costs

Purposes for Employer Coalitions



2. Employer Contributions

TABLE 4.20 FUNDING OF EMPLOYEE MEDICAL COVERAGE